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(8) The facility must demonstrate that it is providing health care services in compliance with Subchapter A of Chapter V of this Title, that it will undertake a program to improve its efficiency in providing such services, and that there is institutional commitment to the continued operation of the facility.

(c) Upon meeting the requirements of subdivision (b) of this section, and upon a finding by the commissioner that a facility is financially distressed, the facility [~~must agree, in writing, to all of~~] shall comply with the following:

(1) The facility shall submit periodic status reports to the Commissioner as he shall specify, which shall include but not be limited to an assessment of the financial condition of the hospital, and a bi-monthly cash flow analysis which details the application of the allowance received and periodic credit reports.

(2) The facility shall develop a plan, subject to the Commissioner's approval, that will improve the facility's financial condition. Such a plan may include provisions to deliver services to the medically indigent and low income patients in a more efficient and economical manner, consistent with quality of care in conformance with Subchapter A of Chapter V of this Title. The plan may also include the reduction of operating costs to the fullest extent possible consistent with quality of care in conformance with the same standards.

(3) The facility shall provide within specified timetables and format, statements of losses from bad debt and costs of charity care as required by section 86-1.3 of this Sub-part.

(4) The facility shall develop a plan for the continued provision of quality health care services which shall include the following elements:

(i) medical audit and utilization review programs;

(ii) periodic reporting of the accreditation status of the hospital's medical education, nursing, and allied health programs where applicable; and

(iii) evidence of continued medical staff commitment to the hospital.

(5) While it is the obligation of the hospital's governing body to manage its own affairs, the hospital's operations and management shall be subject to continuing review by the Commissioner. In consultation with the Commissioner, the hospital shall take such action as required by the Commissioner. These requirements may include the restructuring of the hospital's management and governing body to provide increased accountability and more active oversight, implementation of cost controls and budgeting, and establishment of more accurate and timely financial and managerial reports.

(d) The effective date of the provisions of this section shall be the date upon which the facility becomes eligible pursuant to the criteria of this section.

Reapplication by participants shall be necessary at the beginning of each rate year to recertify eligibility.

(e) Eligibility for the assistance provided within this section shall terminate if:

(1) the hospital fails to continue to meet the criteria and conditions in this section;

(2) upon audit, the facility is found to be lacking the collection procedures required in subdivision (b) of this section; or

(3) a petition for bankruptcy is filed.

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86-1.67 Reserved

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Section 86-1.68: Federal Upper Limit Compliance. In the event the state cannot provide assurances satisfactory to the secretary of the Department of Health and Human Services related to a comparison of rates of payment for general hospital inpatient services to beneficiaries of the Title XIX program determined in accordance with this Subpart in the aggregate to maximum reimbursement payments provided in federal law and regulation which are substantially the same as such assurances in effect on October 26, 1987 for purposes of securing federal financial participation in such payments, such rates of payments shall be adjusted proportionally as necessary to meet federal requirements for securing federal financial participation.

Section 86-1.69 Reserved

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86-1.70 Malpractice insurance (a) Hospital malpractice. The costs of hospital malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among payors [on the basis of payor experience]. Malpractice costs shall be 1981 medical malpractice costs trended to the rate year and allocated as follows:

(1) 8.5 percent of such costs shall be allocated to the non-Medicare payors based on the ratio of [each non-Medicare payor's] their combined 1985 inpatient reimbursable cost to total [non-Medicare] 1985 inpatient reimbursable costs [, and] except for those exempt hospitals reimbursed pursuant to section 86-1.81 of this Subpart. The malpractice costs of exempt hospitals shall be allocated to the non-Medicare payors based on the ratio of their combined 1987 inpatient reimbursable cost as determined pursuant to section 86-1.81(a)(5) of this Subpart to total 1987 inpatient reimbursable costs.

(2) [the] The (Medicaid) share of the remaining 91.5 percent of medical malpractice costs for all facilities shall be [apportioned] determined on the basis of its own experience based on the dollar ratios [for each payor] of the facility's malpractice losses for the 1984 cost reporting period and the preceding four-year period except for those exempt hospitals reimbursed pursuant to section 86-1.81 of this Subpart. The (Medicaid) share of the remaining 91.5 percent of medical malpractice costs of exempt hospitals shall be apportioned to Medicaid on the basis of its own experience based on the dollar ratios of the facility's malpractice losses for the 1987 cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions shall be apportioned among the programs based on the statewide ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(b) reserved

Section 86-1.71 Hospital Closure Incentive Program.

To reduce excess beds by encouraging the closure of hospitals, the Commissioner of Health may consider proposals by hospitals which mutually agree that one or more of the hospitals in the group shall close. The plan must be approved by the appropriate health systems agency prior to submission to the Commissioner of Health. The variable costs associated with the closed facility or facilities including personnel costs, shall become part of the operating expenses of the remaining facilities in the group to the extent that the additional volume experienced by the remaining open hospitals does not generate sufficient reimbursement for efficient operations. The Commissioner of Health may consider a reasonable incentive structure for increased costs of the remaining facilities coupled with a strict attrition program that will, within a reasonable period of time, assure a return to an appropriate level of staffing. Such costs, shall be included only in calculating the hospital specific average cost per discharge pursuant to the provisions of 86-1.54(a).

86-1.72 New hospitals and hospitals on budgeted rates. (a) **New hospitals.** Payments to new hospitals without adequate cost experience for inpatient acute care services that are not exempt from DRG case based rates of payment shall be computed in accordance with section 86-1.52 of this Subpart except as follows:

(1) Rates of payment shall be computed on the basis of 100 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart.

(2) The WEF and PEF used to adjust the group average cost per discharge shall be those calculated for the hospital in the group that is geographically closest to the new facility.

(3) The indirect teaching adjustment shall [reflect the interns and residents per bed ratio used to calculate Medicare rates of payment for the hospital] <u>be determined pursuant to the provisions of section 86-1.54(h) of this Subpart</u>.

(4) The noncomparable operating costs of new facilities associated with direct graduate medical education, ambulance services, organ acquisition, schools of radiology, nursing and/or laboratory technology, and hospital-based physicians shall consist of the hospital's budgeted operating costs for these services, divided by the weighted average case mix index for the hospital's group.

(b) **Hospitals on Budgeted Rates.** Payments to hospitals without adequate cost experience whose rates are based on budgeted cost projections for inpatient acute care services that are not exempt from DRG case based rates of payment

shall be computed in accordance with section 86-1.52 of this Subpart except as follows:

(1) In 1988, the DRG specific operating cost factor shall be computed as the sum of 90 percent of the hospital's case mix neutral budgeted average reimbursable non-Medicare inpatient operating cost per discharge and 10 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to subdivision (b) of section 86-1.54 of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart. In 1989, the DRG specific operating cost factor shall be computed as the sum of 75 percent of the hospital's case mix neutral budgeted average reimbursable non-Medicare inpatient operating cost per discharge and 25 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to subdivision (b) of section 86-1.54 of this Subpart multiplied by the service intensity factor for each DRG set forth in section 86-1.62 of this Subpart.

[In 1990] For rate years commencing 1990 and thereafter, the DRG specific operating cost factor shall be computed as the sum of 45 percent of the hospital's case mix neutral budgeted average reimbursable non-Medicare inpatient operating cost per discharge and 55 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to subdivision (b) of section 86-1.54 of this Subpart multiplied by the service intensity factor for each DRG set forth in section 86-1.62 of this Subpart.

(2) Reimbursement for the costs of graduate medical education and non-comparable services shall be calculated pursuant to the provisions of paragraphs (3) and (4) of subdivision (a) of this section.

(3) The WEF and PEF used shall be those calculated for the facility based on available historical data.

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New York
210(a)

86-1.73 (9/90)
Attachment 4.19-A
Part I

86-1.73 Swing bed reimbursement. (a) Definitions. (1) For purposes of this section, eligible hospitals shall mean those hospitals defined as rural hospitals and meeting the swing bed program requirements in Part 406 of this Title.

(2) Rate shall mean the aggregate governmental payment made to eligible facilities per patient day as defined in section 86-2.8 of this Part for the care of patients receiving care pursuant to Title XIX of the federal Social Security Act (Medicaid).

(b) Rates of payment. Payments to eligible hospitals for patient days resulting from the usage of swing beds in caring for patients for whom it has been determined that inpatient hospital care is not medically necessary, but that skilled nursing or health related care is required, shall be determined as follows:

(1) The operating component of the rate shall consist of the following:

(i) a direct component which shall be equivalent to the 1988 statewide average direct case mix neutral cost per day for hospital-based residential health care facilities, after application of the Regional Direct Input Price Adjustment Factor (RDIPAF) as determined pursuant to Subpart 86-2 of this Part, trended to the appropriate rate year;

(ii) an indirect component which shall be equivalent to the 1988 statewide average indirect cost per day for hospital-based residential health care facilities, after application of the RDIPAF pursuant to Subpart 86-2 of this Part, trended to the appropriate rate year;

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